STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnewaska Community Health Services	605 Main Street Starbuck, MN 56381

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and record review the facility failed to ensure dignified and respectful services for 4 of 6 residents (R2, R3, R4, R5) reviewed who reported concerns related to staff treatment. Findings include: R2's annual Minimum Data Set (MDS) dated [DATE], identified she had moderately impaired cognition and disorganized thinking or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject) that fluctuated and changed in severity two out of seven days of the week. She had impaired range of motion (ROM) upper extremity on one side and bilaterally lower extremities. She required substantial/maximal assistance with upper and lower body dressing, personal hygiene and dependent upon staff for shower/bathing, toileting, roll left and right, sit to lying, lying to sitting, all transfers, and mobility. She was always incontinent of bowel and bladder. Medical diagnoses included: peripheral vascular disease (PVD) (arteries or veins become narrowed or blocked, reducing blood flow to the limbs, typically in the legs), arthritis, osteoporosis, dementia, hemiplegia/hemiparesis (a neurological condition that affects causing weakness or paralysis on one side of the body), seizure disorder/epilepsy, anxiety, and macular degeneration (an eye disease that can blur your central vision). R2's care plan dated 3/18/25, identified a self-care performance deficit and directed staff to transfer her with a Hoyer lift with assist of two staff, provide all ADLs, and turn and reposition in bed. She was at risk for impaired skin integrity and directed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 11:24 a.m. R2 stated she had polio when she was two years old which resulted in no neck muscles and found it uncomfortable when she sat in the wheelchair. Staff hooked her up to the harness (lift sheet) to Hoyer lift, left the room, closed the door, and looked for assistance to transfer her. She stated it made her feel like a horse with a harness and had asked staff to wait until both staff arrived prior to when she was hooked up. Staff rushed when they used the Hoyer lift, had forgotten to move her legs/feet out of the way, pinched and bumped them when staff pushed the emergency button on the lift machine and lowered her down quickly. While staff positioned her to be transferred from bed to wheelchair today, she was instructed to place her hands on her chest and hold her head up. She reminded staff to be careful of her feet, while staff pulled the emergency lever on the Hoyer lever and lowered her down quickly into the wheelchair. She was afraid her head would be hit by the Hoyer lift bar that hung over her head. She had been knocked in the head more than once by the Hoyer bar while she was lowered too quickly. On another occasion she was lowered into the wheelchair and the loop on the lift sheet had hit her in the eye. Staff had pulled her shirt off quickly and her right arm hurt. Her daughter called DON and was told she would talk to staff. She also reported this to the director of nursing (DON) and was told she would talk to the staff. She felt safe but uncomfortable with staff and frustrated when she reported concerns, and no changes noted. She identified a nursing assistant (NA)-A that was not her favorite. NA-A handled her roughly and worked fast, always in a hurry, never hurt her but she had screamed and yelled when her right arm was not handled gently, no bruises or injuries thank goodness. She was able to assist when staff requested her to turn to her right side, grabbed the bed railing, but was not allowed the time, and turned quickly by NA-A. She had cried more than once, felt disrespected, did not feel like home to her, and wanted to move out of facility. NA-A had continued to use the emergency button on the Hoyer lift and reported how she was treated by NA-A to the DON and planned to talk with DON again today. She stated she felt staff could treat her better and with respect. R3's quarterly MDS dated [DATE], identified intact cognition with no behaviors. She required substantial/maximal assistance with upper and lower body dressing, personal hygiene, roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, dependent on staff for toileting hygiene and bathing/shower. She was unable to ambulate. She was always incontinent of bowel and bladder. Medical Diagnoses included: cancer, congestive heart failure, diabetes mellitus (DM), anxiety, obesity, and depression. R3's care plan dated 3/19/25 identified ADL self-care performance deficit and directed staff to establish a routine to provide a sense of security and confidence with resident, provide moderate assistance of one with bathing, bed mobility, incontinent brief changes, anticipate needs, and transfer with assist of two and sit to stand lift. Allow resident to accomplish tasks at her own pace, do not hurry them, and encourage independence only when resident was able to safely do so. She had potential for impaired skin integrity. Staff were directed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. She was prescribed an anticoagulant and staff were directed to protect resident from injury and trauma. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 10:13 a.m. R3 stated staff transferred her with a stand lift. She was concerned about her tender feet when taken to the shower by NA-A. She was placed into the shower/tub, feet first, her feet had gotten bumped into the inside to the tub and was painful. She no longer allowed NA-A to take her to the tub anymore. NA-A was rough with how she handled her, reported to management, was told no one else complained about her, and nothing was done. She allowed NA-A to transfer her with the stand life in her room only but watched where her feet were placed so that they did not get jammed somewhere. She stated she felt safe because she was able to speak up for herself but worried about those residents that were unable to say anything. NA-A had informed her not to tell her how to do her job when she encouraged her to slow down, watch her feet, and adjust incontinent brief when not placed properly. Her stools were horrible, runny, and when NA-A rushed while she placed the brief on improperly caused a mess in the bed, which not only caused quite the smell but embarrassment. NA-A told her she should spend some of her money on something to help the stool smell in her room. R4's quarterly MDS dated [DATE], identified intact cognition without behaviors. She had impairment ROM bilaterally upper and lower extremities. She required substantial/maximum assistance with oral hygiene, upper body dressing, personal hygiene, roll left and right, and dependent for all transfers, sit to lying, lying to sit, unable to walk, and used a motorized wheelchair for mobility. She had an indwelling catheter and frequently incontinent of bowel. Her diagnoses included: quadriplegic (a condition characterized by partial or complete paralysis of all four limbs, arms, and legs), depression, and anxiety. R4's care plan dated 3/24/25, identified she had an ADL self-care performance deficit and directed staff to allow sufficient time and assistance for her to dress and undress, she required assistance of two staff and a mechanical lift to transfer, and anticipate her needs. She had potential impairment to skin integrity of the coccyx related to quadriplegia. Staff were directed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/25 at 12:53 p.m. R4 stated the care at the facility was sometimes questionable. Staff rushed too much, lacked taking the time needed to complete tasks properly. Her catheter strap was located on the side of the leg and pants were not pulled up straight, later she had pressure marks on her leg. Staff failed to recognize the lift sheet was pulled up too tight between her legs during a transfer with the transfer lift and resulted in red marks in the groin area. She had not felt safe during a few of the total lift transfers especially on Tuesday when the lift sheet was placed too low on her hips and she had to be placed back on the bed crosswise during the transfer. She became anxious when things were not positioned correctly when she drove and when she had a spasm could have caused an accident. She preferred staff used the soaker sheet when they turned onto her side so that they avoided pulling /pushing on her. She was able to turn herself if only the staff would have slowed down an allowed her help. NA-A frequently used the emergency button on the total body lift machine, showed other staff how it was to be used, felt worse when she did, too fast and resulted in a bumped shoulder on the lift bar. NA-A had placed her in the shower chair, rushed too much, and bumped her feet. NA-A told her, another resident along with her should have not been placed in the same hallway, could not spend that much time helping us. There were a few other staff that had told her it had taken too long to take care of her. Those types of comments/actions of staff did not make her feel very well. She felt she was time consuming, angry, and irritated. She stated she told staff when they were rough with her during cares that hurt, to knock it off. She was in this facility because she required help and unable to live at home and independent once the staff assisted her up out of bed in the morning and completed cares. She had told a staff NA about her concerns and felt comfortable talking to only certain staff about her concerns. R5's quarterly MDS 12/27/24, identified intact cognition with no behaviors. She had impaired bilateral lower extremities range of motion (ROM). She required substantial/maximal assistance with roll left and right, dependent on staff to provide oral/toileting/personal hygiene, shower/bathing, upper and lower dressing, sit to lying, lying to sitting, sit to stand, and all transfers. She was unable to ambulate and used a motorized wheelchair for mobility. She was occasionally incontinent of bowel and always incontinent of bladder. Her diagnoses included: CHF, DM, and arthritis. During an interview on 3/27/25 at 9:27 a.m. R5 stated NA-A was a little rough with her approach when she cared for her. She was unable to turn herself in bed, NA]-A was stronger than the rest of the staff and without warning would be pushed over to her side rather fast and was unexpected. NA-A was the only staff that rushed through cares, and she had not reported anything. She was a bigger resident than most and did not feel it was intentional but when she talked with other residents, they did feel it was. NA-A used the emergency button on the Hoyer lift when she transferred her. NA-A usually waited until her bottom was on the bed or until her wheelchair was reclined, braced herself and then the emergency button would be pushed. There were times when her back was not placed down on the bed, approximately four inches away and NA-A pushed the emergency button on the Hoyer lift, and she felt a jolt. During an interview on 3/26/25 at 3:44 p.m. licensed practical nurse LPN-(A) stated on 3/24/25, she reported to the DON possible concerns she had regarding NA-A cares provided and transfer with a total lift machine. Later that same day, NA-B reported to her NA-A moved fast when she completed cares and transfers, used the emergency button on the total lift machine so that multiple residents were lowered down quickly into the chair and/or bed. She did not report that information and should have. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/26/25 at 4:45 p.m. NA-A and NA-B entered R2's room with a lift machine. R2 laid in bed on her back. Both NA's applied gloves and explained she would be transferred to her wheelchair for supper. Lift sheet, dark blue with green trim, was placed underneath her by rolling her slowly from side to side. Head of bed (HOB) was raised, and shoes applied. NA-A placed the loops of the lift sheet onto the lift machine and lifted her up off the bed with the remote control. NA-A moved the lift machine over to the wheelchair and slowly lowered her down onto the wheelchair. The emergency button was not used. NA-A and NA-B removed the lift sheet loops from the lift machine, tucked the lift sheet into the sides of her wheelchair and underneath her thighs, removed gloves, and sanitized their hands. During an interview on 3/26/25 at 4:56 p.m. NA-A stated the lift machine had an emergency button used to lower residents down quickly. She had used the emergency button once while she transferred a resident, and the battery was almost drained. She had not used the emergency button during a transfer since. Staff were educated the emergency button should have not been used for regular transfers or when a resident was in the lift. A resident would not get injured if the emergency button were used and lowered too quickly. She treated residents well, provided cares efficiently, and safely. She had not witnessed any staff treat residents in a poor manner or received any complaints from residents. The DON interviewed her on 3/25/25, regarding transfers and cares completed on 3/24/25. During an interview on 3/26/25 at 5:20 p.m. LPN-B stated he had assisted NA's with transfers with the total lift machine. He had been informed by staff NA-A had been rough with R3. He talked to R3, and she told him NA-A was not the most gentle touch, seemed to feel it was not too terribly rough, and no other comments. He had not received any other complaints about NA-A and was that information was not reported. During an interview on 3/27/25 at 10:47 a.m. NA-D stated the emergency button on the total lift machine was to be used only during an emergency. She had completed total lift machine transfers with NA-A and encouraged by NA-A to use the emergency button during the transfers especially on those residents that were heavier, so they were lowered down faster. The emergency button on the total lift machine was hard to pull. She was instructed by NA-A on how to emergency button should have been used and when she did it jerked the resident while they remained in the lift sling. She had not witnessed a resident hurt by this process but when used frequently could have possibly caused an injury. She had noticed since 2/19/25, NA-A worked fast and there were three residents that had informed her NA-A provided rough care. R3 informed her NA-A bumped her feet during transfers and refused to allow her to transfer or be pushed around by her anymore. R2 informed her during transfers had bumped her head with the lift machine bar, feet, and lowered quickly down into the bed or wheelchair. She was not sure if that was unusual, staff worked at different paces. R4 had told her staff rushed through cares, flipped over onto her side too fast, was not allowed time to assist with turns when able to, and felt frustrated and disrespected. The complaints were not reported but realized now she should have said something. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 12:10 p.m. NA-B stated NA-A was rough with the residents, very strong, and completed tasks quickly without thinking. She had told NA-A to slow down, it was not a race and would prevent injury to the residents. During repositioning or when a resident was turned NA-A used her hands, pushed on the wrong spot on the body they maybe sore already, and turned them quickly, causing more pain. She had seen NA-A transfer residents, without paying attention to the location of their feet and their head and they have gotten bumped. She had completed total lift machine transfers with NA-A and witnessed her rushing through the transfer placing the resident's safety at risk. She received complaints from residents R4, and R2, NA-A was rough and flipped them over too fast during cares. She has not witnessed any bruises or injuries. She had talked to LPN-A regarding her and resident concerns and encouraged residents to report concerns to the nurse on duty or the DON. The emergency button on the total lift machine was to be used only in an emergency, not daily. The facility had some heavier residents, was unsafe to be dropped down fast and could have possibility been injured. She had informed staff if they did not like working with old people, treated them poorly, they should have looked for a different job and would be reported. During an interview on 3/27/25 at 2:46 p.m. NA-C stated she had noticed there were staff NA's were rough with residents when moved or repositioned with their hands instead of using the soaker pads. She witnessed R3 requested to be boosted up in bed and NA-D replied, no. She was in a resident's room and heard NA-A stated in front of the resident how annoyed she was when the resident used the bed remote and placed her bed up and down frequently, cord pulled out of the wall, happened every night, had to get down on the floor, and plugged it back in. Had not reported concerns right away and on 3/25/25, in the afternoon she reported her concerns to DON. During an interview on 3/28/25 at 10:04 a.m. DON stated she was not aware of any concerns with residents being treated inappropriately by staff. R2 complained about her wheelchair and was looking for another place to move to. R2's daughter had not contacted her regarding concerns on how she was being treated at the facility. On 3/24/25 she had interviewed five residents all located on the same wing in the facility. Those residents were asked how they were doing, any concerns, and all said things were fine. She stated the residents would have told her if something had bothered them. During an interview on 3/28/25 at 12:15 p.m. administrator stated she was unaware of any resident concerns treated inappropriately by staff. We have great policies, need to be followed, and concerns would be expected to be reported right away. When concerns were identified interviews were expected to be completed with all residents in the facility. She had not received any complaints from staff or residents regarding staff. On 3/27/25, DON informed her about concerns and lack of staff reporting. Staff were terminated on 3/27/25. Facility policy Promoting Maintaining Resident Dignity undated identified it was the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, which maintains resident's quality of life by recognizing each resident's individuality. Staff were expected to explain care or procedures before initiating the activity and speak respectfully to residents.